

CHALLENGES IN RURAL AMERICA: VA ACCESS AND MENTAL HEALTHCARE

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES

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CHALLENGES IN RURAL AMERICA: VA ACCESS AND MENTAL HEALTHCARE

Wednesday, August 6, 2014

COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The committee met, pursuant to notice, at 11:15 a.m., at the Roswell Convention and Civic Center, 912 North Main Street, Roswell, New Mexico, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller and Lamborn.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. The meeting will come to order. Before I begin, there's something we need to take care of today. And I would ask unanimous consent for our colleague, Steve Pearce, to be allowed to sit at the dais today and participate in today's proceedings.

Without objection, so ordered.

Good morning, everybody. I'm pleased to be back. It was one year ago that I had my first opportunity to come to Roswell after driving down from Albuquerque with Congressman Steve Pearce. So it's a pleasure to be here.

I'm Jeff Miller, Chairman of the House Committee on Veterans' Affairs. I flew in this morning from Pensacola, Florida, where we have more water than you do, Steve.

I'm joined by senior committee member from Colorado, Doug Lamborn. I'm pleased to have him here today. And, of course, our friend and colleague, Steve Pearce.

The CHAIRMAN. I know I speak for Representative Lamborn because we both feel the same way. Our friend, Steve Pearce, is a dedicated member of Congress. We actually sit together on the floor of the House almost every time we have a series of votes.

And I know that he is keenly interested in the veteran community and the things that are going on not only here, but all over the United States of America. So it's a pleasure, Steve, to have you joining us today.

Mr. PEARCE. Thank you.

The CHAIRMAN. And I'm grateful to him for inviting us to come back and have a chance to listen to some individuals who are going to testify today.

Before we begin, I'd like to just ask, you're a veteran, please stand. If you are not able to stand, raise your hand. We want to recognize you and say thank you for your service to our nation.

The CHAIRMAN. Again thank you so much for your service and continuing to help, as do many of you here in Roswell, your fellow veterans.

Ensuring that you and your neighbors and colleagues in New Mexico and around the country have timely access to quality healthcare through the Department of Veterans Affairs is why we're here today. I'm grateful to each of you for joining us because it is a very timely topic that we discuss right now.

As you know our committee has been involved for quite some time, but in a much more diligent fashion, holding two full committee hearings a week through the summer months because of the crisis that exists right now within the Department of Veterans' Affairs.

We knew that there were wait times, we knew that there were issues. What we did not know until recently, and I say recently, late last year, when we actually started investigating, was the corruption, the lying, the cheating, and the stealing that was going on by some employees within the Department of Veterans Affairs as it relates to wait times.

Because of that, we fashioned a piece of legislation that the President will sign tomorrow that I think will go a long way to starting the process of fixing VA.

One thing is you cannot legislate morality, you cannot legislate common sense, you cannot legislate people doing the right thing. But what we did do was give the Secretary the ability to fire individuals who aren't doing their job or who find that they forced other people to manipulate the numbers so that they can receive bonuses.

We still think there may be some potential criminal claims that may be lodged against some of these supervisors because to change numbers at the federal level to get a promotion or a bonus of some type is, in fact, a violation of the law. We have asked the Department of Justice and the FBI to get involved, and they have.

In the four months since this broke, April 9th was when we actually broke the story, CNN has covered it quite ostensibly. They didn't even really start covering it until the end of April. But we have held as I said about two meetings a week. And we have continued our oversight.

Now, for people all across the country, the media will have you believing that we are on a five-week vacation. That's not quite what the August recess is supposed to be.

The August recess is supposed to be an opportunity not only for us to go back and reconnect with our constituents, but also to travel all across the country as I do as the chairman, as Doug Lamborn does, and as Steve will do with me tomorrow when we go to El Paso to look at the issues over there as well.

We are continuing to keep shining a light on VA to make sure that they, in fact, are changing the way they do business. Unfortunately it's not going to change overnight. You know that. It didn't happen overnight, it's not going to change overnight.

But I think the new Secretary has the right attitude. My caution to him is don't let the bureaucracy eat you up, because that's what happened to Secretary Shinseki. The unfortunate thing about the Secretary's departure is that the very people that caused the prob-

lems are still employed by the Department of Veterans Affairs. But the Secretary was lied to and he's gone.

So, you know, the VA's nationwide access audit found troubling scheduling practices were in place in Albuquerque at the medical center there. And we're going to hear from some of our witnesses this morning about issues that they have had to confront.

And, look, it may not all be bad. I'm not here just to hear the bad stuff. I want to hear some of the good things, because out of the 330,000 VA employees that are out there today, let me assure you that there are a lot of good ones that are going to work every day at the VA because they want to serve veterans and because they want to do the right thing.

But we've got to fix the problem and get rid of the people who are the dead wood inside that system so that you are served better and you get the care that you've earned.

I look forward to our discussion this morning. I thank you all for being here. I will now turn to my good friend Mr. Lamborn for his opening statement.

Mr. LAMBORN. Very briefly, thank you, Mr. Chairman, for having this hearing. It's great to be in Roswell, it's great to be among veterans.

My father was a World War II veteran. He passed away a couple of years ago. He fought in 11 campaigns in North Africa, Sicily, and Italy. And it changed his life. I mean it made him a different person.

It was something he talked about. He was someone who talked about his experiences. And almost every day for the rest of his life. And so it was just great to sit at his feet and learn about the greatest generation.

And then my oldest son has served in the Army. And one week after high school he was in for three years, serving in support of the 82nd Airborne at Fort Bragg. So I'm honored to be part of the VA committee.

And let me just say, Chairman Miller, you may already know this. But he is so dedicated to veterans, his care and his concern and stewardship of the taxpayer dollars, and the clinics and hospitals. He's doing such a great job. But you know that. And that's why he's here in Roswell, that's why we're having this hearing.

So it's an honor to serve with him. And it's an honor to serve with Steve Pearce. As a veteran himself, he knows these issues. But beyond that Steve Pearce is legendary in Congress for his dedication to the person, a person off the street living in his Congressional district.

They've written about him in The Wall Street Journal. And I don't want to embarrass you, Steve. But he sets a great example that many of us appreciate and learn from and have benefited from. So it's just great to be here, Mr. Chairman. Thanks for having this hearing.

The CHAIRMAN. Thanks very much, Doug. I'm going to recognize Congressman Pearce in just a minute and introduce our witnesses.

But first I want to thank them for their presence here today and for participating in this hearing and doing all the things that you do for the veterans in this local community and around this region.

I would also like to gently remind you, if possible, we do have a five-minute opening statement rule. What will happen is these little lights will pop up. It will go green. And when you get to one minute, it will go to yellow. And then when you get to red, that means your time is expired.

Now, if you go longer than a minute after red, I can't promise what will happen. We want to hear your entire statement. So they are here certainly to kind of help keep people on time with their statements. But we appreciate you being here to talk to us.

At this time let me ask Steve Pearce if he would introduce our panelists. Thanks.

Mr. PEARCE. Thank you, Mr. Chairman. Thank you for being here. Also thanks, Mr. Lamborn.

OPENING STATEMENT OF HON. STEVE PEARCE

Mr. Lamborn last night was going to get on the plane to come here. They had thunderstorms that were going to keep him from flying. So he and his wife got in the car and drove here. So I think we need to recognize the dedication that people have when they make commitments in Congress. It's a very serious thing.

The reason we're here today has been amplified in the last two days since I've been home. Since being here back in New Mexico, I ran across one veteran that was driven from here to Albuquerque to receive an injection in the index finger.

That's the reason we have set this pilot project up here today, to stop using those kinds of long trips for things that could be done locally.

Another veteran that we saw just yesterday in Jal had hearing loss from cannon fire back in Korea. His hearing aids broke. They sent him to the VA in Big Springs.

Big Springs VA paid him miles to go there. Big Springs sent him to Albuquerque the next week. They paid him mileage there. They kept him there three days. After assessing him, then they returned him back to Big Springs and said he ought to have gone there to start with.

And then he finally got the hearing aids and they didn't work so he's still using his old ones. And it's that sort of ineffectiveness and inefficiencies that cause veterans tremendous problems.

Then this morning I was on a call-in radio program. The young lady carried her 88-year-old father yesterday to the Artesia clinic. She had a card in her hand for the appointment time. It was made for 31 days later.

They showed up. And they said they had no record. They were three veterans trying to get into the Artesia clinic just yesterday all with the same problem. And the arrogance of them is what really made people mad.

The arrogance that you don't have a right to be here, we told you, you don't have an appointment, while they're holding the cards. These are the things that drive us all.

Today we have John Taylor. He was a combat sniper in Vietnam, a hospital administrator in his private life. He has a 100 percent disability rating for PTSD. He's been an advocate for veterans throughout New Mexico. He's a contributor to the Roswell Daily Record on veterans affairs.

Secondly, we have Richard Moncrief, a veteran living with PTSD. He'll talk about services due to limited access to physical doctors he declares to be less than viable. He's a veteran service officer for New Mexico Veterans Department. He works on a daily basis for the betterment of our veterans.

We have Harry McGraw that was scheduled on this first panel. I'm not sure if he's on a later panel. I'll introduce him later if he's going to come up. But again we appreciate Chairman Miller remembering his promise and coming back here.

I would like to also acknowledge that the VA in Albuquerque has been cordial in two visits since the problems were first noted by the chairman and became a national crisis.

Those meetings have been congenial, they've been transparent, they have honored the promise that we would indeed set up a pilot project. It's ongoing today and for a couple of days where we're actually letting local veterans see local providers.

When the VA's problems erupted nationwide, there was a kind of a clamor to take a look at what we might do. And I appreciate the fact that Chairman Miller looked back at what's called Healthy Vets that we've had filed for the last four Congresses, for the last eight years, basically saying, if you have to drive more than a certain distance, you can go to your local providers.

So Chairman Miller inserted that as one of the key provisions in one of the most dramatic reforms in the VA system since its inception. I think that the chairman has done a tremendous job in getting this bill through.

It's approved by the House, Senate, and is set to be signed by the President later this week. So I just think, if it's approved in committee procedures, I think we ought to give the chairman a round of applause for remembering the rural veterans of this country.

Mr. PEARCE. The VA has a lot of people who care deeply about the veterans. And they serve well and they do their job well. But the abuses and the problems have dominated.

And that's the reason that we're here in Roswell today, to hold the first hearing nationwide after the passage of that historic legislation. And the chairman will see the pilot project in operation here in Roswell today.

So thank you very much for being here. And I will yield back my time, Mr. Chairman.

The CHAIRMAN. Thank you very much, Steve.

And we will begin with Mr. Taylor. We recognize you for your opening statement.

STATEMENT OF JOHN TAYLOR

Mr. TAYLOR. Chairman Miller, Congressman Lamborn, and Congressman Pearce, it is an honor to provide testimony before you today.

My active duty combat military experience was with the 101st Airborne Rangers in Vietnam. After seeing many of my brothers die in heated combat situations within the infamous A Shau Valley area of Thua Thien/Hue and being shot twice and bayoneted on the same day, dying on the MASH unit surgery table, and obviously returned to life, I never imagined any of us would come back home to die directly related to post-combat medical care in our VA hos-

pitals. Sadly, as you are now aware, that has become a painful reality.

In the interest of saving this committee time, with respect to my evaluations and solution recommendations, the last committee hearing we held on "Service should not lead to suicide," one of my fellow compatriots, Sergeant Josh Renschler, had a very good, very detailed analysis. And I would put that as a reference to what I have coming up.

For my side, I would like to look more at the unique situation that we have here in our area of Southeastern New Mexico, a significant variation that I would term 'acute rurality'. Being in a rural desert community, systemic problems encountered throughout the country are greatly intensified in Southeastern New Mexico.

As a quick example, following the CARES Commission findings during President Bush's last term in office, a Director of Rural Administration was created to help eliminate our acute problems with rural access in our area.

As it turned out, that rural administrator responsible for resolving our problems was none other than our administrator of the Albuquerque VA Hospital, obviously the very person historically refusing our requests for local fee-based services. Ineffectual outcomes are obvious. A fox in the henhouse type situation.

For the last nine years, I've published a weekly Veterans Advocate column in our local newspaper, the Roswell Daily Record. The column is a volunteered, not compensated, freelance work having no allegiance to any person or group except to my brother and sister veterans.

Over the years I've made members of both sides of the aisle uncomfortable to say the least. However, the majority of my rants have now shown to be true. Like so many of the other public forum veterans' advocates, we're asking why did it take the recent deaths of so many of us to prove what we have been claiming for so many years, over ten as far as myself goes.

It is important to note that our deaths were majorly not due to medical care provided by our VA medical professionals. Physicians, nurses, support personnel, and even support administrative people are doing a great job. That goes without question.

But the administrative games played by VA administrative leaders and by system oversight groups, that's the problem. I've made that statement publicly several times over the past nine years only to be ignored and politically told either we're working on a resolution or you're not correct in your accusations.

Finally, saddest of all, my claims have been validated with the many deaths recently uncovered and still being uncovered thanks to courageous whistleblowers within the system. Veterans' families and friends have continued to not come forward due of fear of reprisal. You guys have seen that in action also.

The VA has historically denied this to be true. But as you yourself have recently seen, the VA seems to have a problem with the truth. I personally can offer proof that this has occurred long before the recent awakening.

I respectfully submitted a few of my VET ADVO columns in support of my testimony today, most of which are six to nine years old. But it's the same theme coming forward.

This illustrates real-life catastrophes I have encountered over my nine years as advocate, which were literally ignored or denied as being accurate by our state VA administrators and government officials.

We all know now how invalid the VA denials were and still are. Two specific sets of columns illustrate factually the problems and battles we have faced with the Albuquerque VA Hospital administrators, consistently denied by the VA as being accurate.

Number one, the first was a series of columns I did on a chronic PTSD veteran who over the space of more than one year threatened to commit suicide due to his Desert Storm nightmares. His wife approached Colonel Ron McKay, USMC Retired, and me with horror stories of her lack of effective treatment for her husband by the VA.

Apache, my column name for my brother to respect his privacy, had undergone several treatable modalities listing from three days to three months inpatient sessions. More than once he was sent home in a cab for a two and a half hour drive, before which he would ask the driver to swing by the nearest Albuquerque liquor store to make his journey easier.

His primary substance abuse/dependency directly related to his PTSD was alcohol. Knowing this his treatment team and/or patient discharge planner should have known this was a perfect storm doomed to failure. Each time Apache returned home totally inebriated, once again threatening suicide.

He was instructed by his VA treatment clinician to report to a local VA social worker for aftercare. During the first visit by Apache and his wife, as reported by his wife, the counselor asked, "So what is it you want me to do? You know, you could go to the A.A. and get some help." So a furious Apache and his wife got up and left.

In my experience as a director of a psychiatric center and an inpatient substance abuse center, aftercare for either malady requires at a minimum the services of a certified psychiatric counselor or certified substance abuse counselor. In Texas and New Mexico, this is required for licensure, not a social worker.

Eventually Apache was found dead one night outside his house in spite of repeated requests to the VA for help keeping him alive. The VA response? He was noncompliant. In other words, they gave up.

The second set of columns dealt with several cases that I did through the years. One in particular was an 87-year-old veteran who I was proud to two or three times a month drive to Albuquerque, a three and a half hour round trip. He had an active catheter. And his 87-year-old wife, who was in poor health, did the drive. There's the problem.

His response to me several times was, "My people don't lie." I have reliable witnesses to that encounter. This was in a situation where I had actual proof that the VA did, in fact, lie. Not miscommunicate as politically correct, but lie.

And when I approached the administrator, he didn't want to hear it. He said, "My people don't lie." I said I can give you incontrovertible truth. "My people don't lie. You're done."

All right. Last week I measured the actual distance from our nearest CBOC in Artesia and found it to be about 45 miles. We've been excluded from a lot of the improvements because we didn't qualify for the "less than 40 mile" rule. Obviously I'm 45 miles so I'm five miles over that limit.

I apologize for this lengthy testimony. But after nine years of reporting on these issues and warning everyone of the obvious, predictable outcomes, I hope this report does not once again fall on deaf ears.

Simply stated, systems monitored by its own department members, no matter the claims of independent watchdog status, do not and will not work. Paying bonuses to upper echelon administrators is a crafty mechanism created by upper management to milk the system. I know. I've been there.

In my many years as a medical administrator my reward, bonus, if you please, was continued employment for the next year. That was my bonus. The contrived reason for VA bonuses reported in other House and Senate committee hearings is to entice and retain competent administrators.

That, Honorable Committee Members, is a fallacy perpetrated on those who have not worked in the medical arena. Competence in our current VA administration based on this bonus rule has been proven grossly lacking among our current VA handpicked wonder kids.

In my experience it's safe to say you would find a sufficient queue of qualified applicants for each VA administrative position you currently find not up to par. Current doctors and medical administrators being RIF'd, which is reduction in force, in the administration's military drawdown could easily and effectively be placed in certain comparable positions recently found lacking in the VA administrator network.

I sincerely hope my testimony and attached resource materials will help you with your enormous task of keeping my brother and sister veterans alive once they return home after surviving death on the battlefield.

I would be pleased and honored to answer any questions you may have of me. God bless you in your efforts, God bless our brother and sister veterans, and God bless our nation. Thank you.

[THE PREPARED STATEMENT OF JOHN TAYLOR APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Taylor. And we'll ask questions after everybody has already given their testimony.

Mr. Moncrief, you're recognized here. Please go ahead.

STATEMENT OF RICHARD MONCRIEF

Mr. MONCRIEF. Thank you. I would like to thank the committee for giving me the chance to speak out about the lack of mental healthcare in the southeast corner of the state.

I have been using the mental health services in the Artesia clinic for several years now. With the loss of Dr. Peter Hochla, we are

now being forced to use the telemed system, which is a very impersonal way of conducting mental health.

The men and women who suffer from PTSD and TBI need to have a live physical being to talk to. Better yet to have group therapy with a skilled group leader and a psychologist would even be better.

Having a warm body to talk to in person is better than a flat screen for a patient. The talk is more personal and you can see the body movement and make better eye contact with the person doing the counseling.

Dr. Hochla, when he would come, he would come every three to six months and make appointments for people. Well, I still needed somebody to talk to because I had to let my hair down and relax every once in a while.

I ended up hiring my own Licensed Professional Clinical Counselor. I tried to use TRICARE since I was retired, but they didn't pay enough money. They didn't pay up to Medicare standards. So I ended up paying for the counselor myself. And there's a great need for some kind of skilled counselor in this part of the country.

There are many more problems that need to be addressed. I have been given medication to increase my blood pressure after the hospital had already told me I had high blood pressure.

Is the pharmacy or the doctor supposed to check to see if there's a problem or is it my job as a working person without medical experience to see if the medication is bad for me. I take it it would be up to the medical staff to figure that one out.

I was given a hearing test last year at the VA Medical Center. The doctor said my hearing had gotten worse. I didn't receive hearing aids. I asked why. He didn't say.

So here in town this lady invited me to come over to check on a hearing test. And after giving me a hearing test, she said yes, my hearing was getting worse and it would be best if I got hearing aids for both ears before I lose my hearing totally.

There is a shortage of housing spaces for homeless veterans in Southeast New Mexico. I have had to send people to Albuquerque to get any help either way or we have to find funds to be able to put them up in hotels and money to feed them.

The major problem of veterans having a nice resting spot now has been solved here in the City of Roswell. We now have our own veterans cemetery that's been dedicated and it's in use as of today.

I had to call the Hospital Executive Assistant to the Director to have my 100 percent total disability and permanent disability put in the hospital computer after nine months of waiting. The hospital didn't even recognize that I was 100 percent disabled.

And now my last question is why do veterans have to drive 200 miles to get medical attention in Southeast New Mexico? Thank you.

[THE PREPARED STATEMENT OF RICHARD MONCRIEF APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Moncrief.

I understand Ms. Tschabrun is a late addition to the witness table. We appreciate you being here and willing to stand in. Thank you for what you have been doing. If you could in your statement tell us a little bit about what Lovelace is doing.

STATEMENT OF DAWN TSCHABRUN

Ms. TSCHABRUN. Thank you, Chairman. Congressman Pearce, thank you. My name is Dawn Tschabrun. I am the CEO, chief executive officer, of Lovelace Regional Hospital here in Roswell.

I'm coming to you today to say that we've seen some improvements. The Demonstration Project is working. As of this morning, we've seen five veterans in our clinic and it's been very, very successful.

We will see a balance of nine by the end of the week. And it's been a huge satisfier to our veterans who live here in Roswell as well as in Southeast New Mexico. So kudos and thank you for that.

My other comment is Lovelace stands ready to come to the table and discuss the needs of veterans in Roswell and Southeast New Mexico to eliminate travel to Albuquerque so that veterans can be seen at home.

We have qualified, competent care providers from physicians to nurse practitioners right here in Roswell that are willing and able to serve our veterans. Thank you very much.

[THE PREPARED STATEMENT OF DAWN TSCHABRUN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. What we'll do now is we'll start a round of questions. We'll go through one round and then we may have a second round.

And, of course, in the legislation that will be signed tomorrow, it does have a 40-mile requirement; if you are further than 40 miles, the VA has to allow you to go outside the system if you choose. In the past the VA has had the ability to do that.

They've obviously made it very, very difficult. This is supposed to open that gate specifically for the rural communities, much like Roswell.

And, look, in the panhandle of Florida, where I live, we have more veterans than any Congressional district in the country. We do not have a VA Hospital, my veterans have to go to Biloxi.

So they have about a three-hour drive to go to the hospital. We have three major medical facilities in Pensacola. It just doesn't make sense.

But let me also tell you that this entire process is in no way an attempt to tear the VA apart brick by brick. We're trying to help supplement what they already do with local providers, local facilities, because it's better for the veteran, it's better for the taxpayers.

They don't have to pay for mileage to Albuquerque and putting somebody up only to get there and find out your appointment has been cancelled and you have to turn around and come back tomorrow or next week, whatever it may be. A lot of things are going to change.

Now, this is a finite program. It was originally designed because of the wait list that exists out there today. But the intent is that it will carry on. We will have to appropriate more money to it.

There is some fear among veteran service organizations. And probably the most vocal is the Disabled American Veterans. The Disabled American Veterans, they don't like this at all. They think that this is the first step in trying to rip the VA apart.

Again they need to listen to you, the veterans, who have to drive hours to access care and understand what you're having to go through. And hopefully everybody will come to like this program.

Some will stay in the VA, some will go outside the VA and get their healthcare, continuity of care. All of those things are issues that we have to watch and provide oversight to. But our intent is to get the care quickly and ensure quality of care is available to you.

So to Mr. Taylor and Mr. Moncrief, what I'd like to ask is the scheduling issues at Albuquerque, can you kind of go into detail a little bit and have you seen any changes in the way the scheduling has been done over the last several months?

Because we're hearing from certain people around the country that there are positive changes. And we want those changes to be permanent changes, not just temporary.

Mr. TAYLOR. Chairman Miller, Congressman Pearce brought this up in one of his telephone town meetings, has anything changed locally. And I think there are excellent VA hospitals in the country, there are some obviously not. I'll give you a personal example just last week how things have changed.

I have to literally, excuse the pun, pull teeth in order to get dental fee-based service down here in Roswell. So last week I called. And I had a really painful wisdom tooth that was going nuts on me.

So I called the dentist. He said, well, you have to call to Albuquerque and get the approvals. So I did. I called in, I got the dental clinic. It took 50 minutes going down the line, you're the fifth caller. Finally I got to be the next caller. So after 50 minutes, I finally get a ring from the phone.

I get another message saying I'm sorry, sir, the system is down. We're sorry, the system is down, please call back. I did this morning and evening. And I did it the next morning and still the same thing.

So have things improved? I'm hearing not. Some people have said yeah. But certainly in my experience this is an example of trying to get into the system.

The CHAIRMAN. Mr. Moncrief.

Mr. MONCRIEF. I haven't had as much trouble getting appointments. I've been able to clinics. I had to forego an appointment this morning to be on this counsel this morning. I thank you for that.

But I've had a lot of people that have come to talk to me and ask why they're having a problem getting into the VA Hospital, getting into the system. And a lot of people have come in with the idea that they're going to be able to get in into the healthcare system just because they're a veteran.

Well, if you're anything other than service connected and you make over \$30,000 as a husband and wife, you're going to have a hard time getting into the VA healthcare system because the bar has been set. That's as high as it's going to go. It's on welfare.

So there are a lot of people that I had to turn out and say I'm sorry, we're just not going to be able to get you anything. So, of course, they're not going to be able to get appointments.

There's been a few people that have had a lot of problems with appointments. But I have been able to contact one very important

person at the hospital. And she's sitting right behind me back here, Kara Catton. And she is super at taking care of a lot of the problems that I've had to deal with veterans.

The CHAIRMAN. Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman, Ms. Tschabrun, I hope I pronounce your name correctly.

Ms. TSCHABRUN. Close enough.

Mr. LAMBORN. Okay. One of the issues that we need to be really careful about when we start using more fee basis, which is the private sector providing healthcare, is the custody and the chain of custody of medical records.

Because someone may have been going to a VA clinic or hospital for decades and now they're going to like maybe your facility. And it just is important that the medical records have continuity.

So how is the best way to address that?

Ms. TSCHABRUN. There's a couple of ways to address that, sir. What we've demonstrated today and through this week is the VA worked very collaboratively with us and sent those records electronically to us so that our providers here could review the history so that we were not starting from a zero playing field.

Our providers have the opportunity to review that. And then, as we transition that care, you speak of continuity of care. That's essential. Not only for veterans but for everyone.

So as we see those veterans today through the week, we will then put that electronic record back to the VA so they can see what happened in their visit here. So absolutely we can do hard paper, we can fax, we can download to disks, we can transfer electronically through HIPAA secure mechanisms so that we keep that data safe.

Mr. LAMBORN. And it could be a two-way street?

Ms. TSCHABRUN. Absolutely.

Mr. LAMBORN. So after receiving care in your facility, they go back to the VA, it will be returned to them?

Ms. TSCHABRUN. Yes, sir. That's imperative, because the bottom line is patient care, assuring that whoever the patient is, through that continuum of care, that the providers are knowledgeable about what occurred. And if either side fails to do that, then we've let the patient down from my perspective.

Mr. LAMBORN. Well, I think that that's such an important thing. We're going to have to really stay on top of that because there are some IT issues there that may have to be addressed.

Ms. TSCHABRUN. Sure.

Mr. LAMBORN. Also I would like to ask about telemedicine. And, Mr. Moncrief, you expressed concern that, let's say, for counseling or therapy, that there were some things lacking through telemedicine.

We know that telemedicine negates the need for taking a long car trip; however, you have pointed to drawbacks. What are the pluses and minuses of telemedicine in your opinion? And, Ms. Tschabrun, your opinion also.

Mr. MONCRIEF. The problem that I see with telemedicine, sir, is it's great if you are going to take your blood pressure, you are going to do things that surgically you can talk to the doctors and things like that.

But talking to somebody mentally, you need a physical body there; somebody to talk to that you know is concerned about you. How can a TV set tell you you've got—you can't show it. I mean it's a little—it's impersonal.

As far as I'm concerned, it's the wrong way to be doing mental health. You need to have a live human being sitting there that can understand you and see and be able—what are they going to do, request a TV camera? It's not going to walk over and pat you on the back or make you feel better.

Mr. LAMBORN. Ms. Tschabrun.

Ms. TSCHABRUN. I think it's a huge challenge. Quite honestly there is a deficit of providers in certain fields of medicine. So that brought about the telemedicine option.

In Roswell and Southeast New Mexico, extremely rural, it's difficult to recruit some providers in some specialties. And medical schools are not producing at the rate that they had been.

So telemedicine offers a different approach to prevent travel. I think there are some very good uses of telemedicine. Pulmonology, even perhaps cardiology if it's not that initial visit. I think initial visits need to be face to face.

But telemedicine I think can help us bridge that gap. When we do not have perhaps the ability to recruit that provider into our area, it allows us to link into that provider so that we don't have a deficit of care for our community.

Mr. LAMBORN. I want to thank you all for being here. Mr. Chairman, thank you.

The CHAIRMAN. Mr. Pearce.

Mr. PEARCE. Thank you, Mr. Chairman.

Mr. Moncrief, you mentioned in your testimony that you pay for your own counseling service. Where is that counseling service located?

Mr. MONCRIEF. Right here in town, sir.

Mr. PEARCE. And how much did you pay for a session, if you don't mind saying in front of a room?

Mr. MONCRIEF. It was 75 to \$100.

Mr. PEARCE. How much?

Mr. MONCRIEF. Seventy-five to \$100.

Mr. PEARCE. Seventy-five to \$100. In the next panel, I'll be talking about how, in a very heated exchange with myself and the VA in Albuquerque, one of the senior staff members there was declaring he could not get people seen for less than the price of gasoline. How much do you get paid to drive for gasoline?

Mr. MONCRIEF. Over \$160 to go up and come back.

Mr. PEARCE. So you get paid \$160 in gas money. Then you see the psychologist there in Albuquerque and come back. For \$75 and no gas money, you are able to see someone here.

Mr. MONCRIEF. And it's very personal, sir.

Mr. PEARCE. Ms. Tschabrun, you said that you're seeing six or eight people right now, you're seeing five people a day and nine by the end of the week. What's the scope of services provided?

Ms. TSCHABRUN. This is family practice.

Mr. PEARCE. So just typical stuff?

Ms. TSCHABRUN. Just general stuff, general checkups, general reviews, ongoing type of things.

Mr. PEARCE. What is the cost that you are going to be charging for those visits today? I don't want to get into your data. If you don't want to say it, that's fine.

Ms. TSCHABRUN. I would prefer not to say it.

Mr. PEARCE. Okay. That would be fine.

Mr. Chairman, I also notice that the Secretary of Veterans Affairs for New Mexico is here, Mr. Hale, if we could recognize him. Mr. Hale is of service to his company and country and a veteran himself. So thank you for being here.

Mr. Taylor, you have probably as much experience as dealing with the people here in this area. What has been your experience in fee-for-service here in the Roswell area?

Mr. TAYLOR. Overall I found it to be excellent.

Mr. PEARCE. I mean how easy is it to get fee-for-service payment back from the VA? How has the process worked? Can you just call up there and say I feel bad, I can't make the drive, how does it work?

Mr. TAYLOR. Right now the only one that I can use is the dental. And in that case, you know, I do the visit. The dentist will bill the VA for the services. And it's considerably less than what is billed obviously. And then they pay and the dentist accepts whatever.

Mr. PEARCE. Does everybody that wants fee-for-service get accepted for that or is that 10 percent, 90 percent?

Mr. TAYLOR. Well, right now it's 100 percent.

Mr. PEARCE. I'm talking about the last couple of years. If you want to get fee-for-service, you can get fee-for-service?

Mr. TAYLOR. You have to get the approval. There's a fee-based director at the hospital.

Mr. PEARCE. Mr. Moncrief, you appear to be wanting to say something. Do you want to add anything to that?

Mr. MONCRIEF. I'd like to say that, when you go down to the Artesia clinic and they have to get an x-ray, they send you over to the Artesia Hospital. Well, Artesia ends up billing us. And I'd like to know why.

Because it's the VA sending us there, it's not the Artesia Hospital. And the same thing if you get blood work, anything like that, done. You end up getting a bill.

Mr. PEARCE. The gentleman in the audience today that talked about being required to drive to Albuquerque for blood tests and then have to go back to get the results. I mean again you all deal with as many veterans in this area.

When people request to have their blood work done here, blood tests taken here, at least a sample are they given that permission or is that very difficult to achieve? Is that a single, isolated incident?

Mr. TAYLOR. For the most part, let's say the physician at Artesia needs that done. He can have that done and there's not much of a hassle there. Again let me make one statement.

A large chunk of our problems—there's two areas that, if they can be covered locally, it would eliminate a lot of problems. One being urgent care and one being emergency care.

Now, if we can get that done locally, it would be a tremendous savings. Plus it's no fun driving with a 102-degree temperature even 45 minutes to Artesia. Try it sometime. It's not comfortable.

So if we had a local doc in the box or urgent care center and we had the tie-in to an emergency room, that comfortably the vet can feel that it will be paid for. I mean we have the option now.

Like I say, if you've got a problem, call 911 or go to the hospital. Many of my vets go to the hospital and find out they're going to have to pay for it.

Mr. PEARCE. One last question, Mr. Chairman and Ms. Tschabrun. One of the things that I hear frequently from veterans or providers, when they provide service, many in the VA process say you can go see someone because it's an emergency. But then there's trouble getting payment. What is your experience receiving payment for the services provided?

Ms. TSCHABRUN. My experience is that it's very late in payments coming back from the VA that extend beyond other commercial payers.

Mr. PEARCE. Had you ever not get paid for anything and have to go back to the veteran?

Ms. TSCHABRUN. Yeah, that occasionally happens. If we do not receive payment, then we will circle around back to the individual patient and seek payment from them.

Mr. PEARCE. Thank you. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Pearce.

Ms. Tschabrun, one of the things as you well know in the bill and, of course, most of the hospitals know as well is that the language was inserted into the legislation. It mostly was a repetition of existing law.

But it does baffle me that an agency the size of the VA, especially when they have approved much of what gets done, have a hard time with it.

I'd like to know, how has your experience been with the VA in trying to set up the pilot program and have they reached out to you since this legislation passed both houses? Because that's the main focus. Folks need to get prepared. They've got 90 days with which to write the rules in order to implement this. Has there been a proactive part on the VA?

Ms. TSCHABRUN. Absolutely, sir. Polly from Albuquerque VA reached out to our clinic and said I have this list of patients that we would like to get care at your facility, can we arrange those appointments. So they were done right there.

But it was proactive on the VA's part giving us a call. We were notified that we would be receiving X number. We didn't know exactly what X meant. But then Polly was very, very quick to give us the phone call and say we want these patients seen and I'll be shipping their records to you.

The CHAIRMAN. And how quickly were you able to see the patient?

Ms. TSCHABRUN. We made the appointments within five days of notification.

The CHAIRMAN. Do you do that by telephone or do you do it with a letter or a card?

Ms. TSCHABRUN. That was by telephone, sir.

The CHAIRMAN. One of the biggest complaints that we heard and I don't know if it's been a problem here, is that VA in the past has felt like the best way to do it was with the Pony Express.

It definitely was not the time that few chose at the time they chose. You may not have been able to make your appointment. If you can't make that appointment, then you cancelled it and/or you didn't settle in the first place. So that's something that we hope VA will be able to rectify as we move forward.

Let me ask, we talked about the bad things and, John, you talked about that too. I'd like to hear something good about VA. So, John, if you want to follow up with my comment.

Mr. TAYLOR. Definitely. There's a lot of good particularly with the applied—the actual patient care. As I said the care professionals do an excellent job.

Fortunately we have as Richard mentioned Kara Catton and Sonya Brown at the VA Hospital in Albuquerque. They are quick to respond when we've got a problem and then they do a fine job in getting it done.

The problem is they're putting out fires. When I was an administrator, I didn't want my people running around putting out fires. It's just like the next step is a forest fire, which is obviously what happened here.

If you have a forest fire, you find out what caused it. You go to the system and systemically you solve the problem. So it's good to do firefighting. But that should not be the course of business that you take. It's not helpful.

So several times now I just—at Artesia last week, I spent about an hour and a half, which is way over what my physician there says to spend. But we've got several problems.

And after five heart attacks, he needed to do an extended workups on me. He took the time with the personnel out there. And I've heard some mention, well, they're a little short tempered.

Yeah. I guess, if you are facing a bunch of us old codgers, we tend to get on everybody's nerves I'm sure. On the whole they're professional and they get the job done.

So again there are a lot of positives there. It's the possible death outcome that has me concerned.

Again I had a fellow vet that called me. To me he presented as having appendicitis. Of course, I couldn't make that judgment. But he had all the classic symptoms.

I called Artesia. They said, well, if he's that bad, we can take him in about two weeks. We can't take him today. Call 911 or go to the emergency room. Well, he was in bad shape.

Before I could get back to him and tell him, okay, you can go, he didn't have the money to pay for it. So he and his wife were already driving up to Albuquerque.

So here's a guy with an almost 102 temperature and acute abdominal pain, nausea. He can't be seen by anybody and he can't go to the emergency room because he can't afford it. These are the real-life problems. It's just you can't use firefighting as your course of business.

If we had an urgent care center here, what we used to call doc in the box, they can go over and take care of the immediate problem. So you can triage the problem, but you've got to have the first step, which is either the urgent care center, a low cost way of doing something, or the emergency room for critical.

So yes, they're very positive. But we in total have to get on these shortcomings.

The CHAIRMAN. Richard.

Mr. MONCRIEF. Since receiving my 100 percent, I've been able to use the dental clinic up there. And they have been very responsible to me. And I haven't had any problem of getting fee basis down here.

They have gone out of their way to send me down here instead of having to go up there to get certain work done. They do implants and everything up there. But down here they'll let you get local crowns and things like that put on. And I'd like to commend them for the job they've done for me. Most of the time they're very good.

I've had people call me from Carlsbad. A gentleman was—his wife was on chemotherapy. And he was supposed to go up to the dental clinic in Albuquerque to get work done. I called up there, got a hold of one of the doctors, and they gave him a fee basis to get it all done down there in Carlsbad and he wouldn't have to leave his wife on chemotherapy.

So I haven't had problems with them. Certainly I've had a lot more problems using the orthopedics and things like that up there.

The CHAIRMAN. Mr. Lamborn.

Mr. LAMBORN. I want to follow up a little bit more on the medical records issue. Let's say someone is using fee basis and they come to your facility. And they have shipped you the medical records of the past history.

Do you have 100 percent assurance that you are getting the complete set of medical records? If something is left out, that can, you know, trigger a real problem.

Ms. TSCHABRUN. You know, to address that, I can't say with certainty. "I've got all of it". I have to believe in faith that they are sending what is appropriate to send for that specific instance in this—in the demonstration that we're in right now.

I would expect on a go-forward basis that we—as the project continues, as the veterans have choice, that they can then really give that full medical record. And in turn we also turn that back, because it's got to be a collaborative partnership between the both of us to be successful.

Mr. LAMBORN. I just think, as we go forward, this is something to really monitor closely.

Ms. TSCHABRUN. Absolutely.

Mr. LAMBORN. So I look forward to what's being developed here.

Mr. Chairman, that's all I have for this time.

The CHAIRMAN. Do you get the physical record or do you have the ability to put eyes on the VA record or how does it work?

Ms. TSCHABRUN. These records were actually faxed to us. So we have the bulk of, you know, a period of time that their providers went back and reviewed prior to the meeting with that patient today.

The CHAIRMAN. And then your physician or whoever saw them makes whatever—

Ms. TSCHABRUN. Makes their notes.

The CHAIRMAN. Do you destroy then the set of records that you have or do you have the ability to keep them?

Ms. TSCHABRUN. I don't think that we would destroy those records, because they're a permanent part then of a patient being seen. So we would create a patient file in this facility that we saw them in. And then that would be an ongoing file for that patient.

They may become an inactive patient for us. But they may remain active. But we would still maintain that encounter.

The CHAIRMAN. Okay. Mr. Pearce.

Mr. PEARCE. Thank you, Mr. Chairman. I'll just make a couple comments and yield back.

But you were asking for the good things that happen. So as I travel around, we hear those stories of people very satisfied. So we recently ran a poll of all the veterans in the district.

So the result was—I can't remember the exact numbers. But it was a significant number, maybe 45 percent, were extremely satisfied with the care. And so I do like to give those positive things.

Also in our first meeting that we had with the VA after the scandal broke and the Albuquerque VA actually showed up on the list and we had the meeting, we took about six or seven veterans in there.

And I don't remember exactly the records that we made notes of at the meeting. But about three or four of the veterans had problems. But they expressed that they were content with the care when they got there. It was the scheduling or the distance they had to drive or whatever.

And so I like to share those positive things, because there are good people working inside the system. It's just the system has serious flaws and breaks in that system.

And the last comment that I'll make in recognition of both the Albuquerque and the El Paso VA, when we started seeing problems—this is when I was elected in 2002—I kept hearing the same problems over and over. So we made a list of those.

There are about 23 recurring problems. At every meeting, every single one of the 23 things would be a problem. So I did set up corollary meetings with the lead administrator, the head of the Albuquerque VA Hospital.

And to their credit he would bring his assistant. And he would come to different places in this big Second District. Every quarter we would address those. And as they started working from that list of 23 recurring things, those began to improve.

And they were things like sending people all the way to Albuquerque, having cancelled their appointment four days before they get there. And one of the big complaints was they were being paid \$0.11 for gasoline. And that didn't come close to even covering it.

So those meetings have continued and they still continue. And we can pay attention to the smaller things. But the big systemic problems that your committee has uncovered is what we're dealing with and very difficult systemic problems.

So again I appreciate the hearing here. And I wanted to pass along those good things that I do hear along with the criticisms and complaints. And I'll yield back.

The CHAIRMAN. Thank you very much. I want to say thank you to the first panel. We've got a second panel that we want to hear from.

So with that you're excused. And thank you very much.

The CHAIRMAN. I want to go ahead and call up the second panel while they're getting everything set.

We have Lisa Freeman, acting network director for Veterans Integrated Service Network 18. She is accompanied by Dr. James Robbins. He's the interim medical center director for the Albuquerque VA Medical Center and Dr. Lori Highberger, the deputy chief medical officer and mental health lead for VISN 18. Thank you now for being here.

You do need to get right up into that microphone. Don't be afraid, it's not going to bite you. It's very difficult to hear.

And, Ms. Freeman, you're recognized. Please proceed with your testimony.

STATEMENT OF ELIZABETH FREEMAN, INTERIM NETWORK DIRECTOR VETERANS INTEGRATED SERVICE NETWORK (VISN) 18, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JAMES ROBBINS M.D., INTERIM MEDICAL CENTER DIRECTOR NEW MEXICO VA healthcare SYSTEM, VETERANS INTEGRATED SERVICE NETWORK (VISN) 18, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND LORI HIGHBERGER M.D., DEPUTY CHIEF MEDICAL OFFICER AND MENTAL HEALTH LEAD, VETERANS INTEGRATED SERVICE NETWORK (VISN) 18, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ELIZABETH FREEMAN

Ms. FREEMAN. Thank you. Good morning, Chairman Miller, Congressman Pearce, and Congressman Lamborn. I too want to thank all the veterans who are here today for your service to this country.

And I also want to thank the previous panel members. And I look forward to addressing together their concerns.

Thank you for the opportunity to discuss the New Mexico VA healthcare system's commitment to providing veterans accessible, high-quality, patient-centered care and to specifically address rural healthcare and access to mental healthcare in New Mexico.

The New Mexico VA healthcare system serves veterans in New Mexico, Southern Colorado, and West Texas. The New Mexico VA healthcare system includes the Raymond G. Murphy VA Medical Center and 13 community-based outpatient clinics.

The VA Medical Center is a joint commission accredited tertiary care referral center located in the heart of Albuquerque. It provides a full range of patient care services with state-of-the-art technology as well as education and research. It is the only VA medical center in New Mexico.

Approximately 75,000 New Mexico veterans are enrolled in VA healthcare. And 47 percent of those enrolled veterans live in rural areas.

The VHA Office of Rural Health currently supports nine projects, for a total of nearly \$1.9 million in the State of New Mexico. These projects increase rural veteran access to mental healthcare, women's healthcare, primary care, pharmacy services, and neurology services. Five of these nine projects use telehealth to deliver healthcare closer to veterans' homes.

One currently funded Office of Rural Health initiative is home-based primary care for veterans residing in rural areas near Santa Fe and Artesia. The home-based primary care program provides primary care for frail, chronically ill veterans in their own homes.

There is an increased support for group specialty care through the expanded use of clinical video telehealth or CVT technology. The use of this technology in homes is on the rise, especially aiming to assist American Indian veterans who are the most rural, isolated, and transportation challenged.

In fiscal year 2013, the New Mexico VA healthcare system served over 5,000 veterans through telehealth. And 59 percent of these veterans lived in rural areas. Of these 1,000 veterans accessed mental health services through CVT, 90 percent of whom live in rural areas.

The New Mexico VA healthcare system has a robust expanding telehealth program including more than 30 telehealth programs offering additional modalities to CVT including home telehealth, video to home, storage for telehealth, secure messaging, e-consultations, and Specialty Care Access Network-Extension for Community healthcare Outcomes known as SCAN-ECHO.

The New Mexico VA healthcare system has been aggressive in providing comprehensive mental healthcare for veterans from prior wars and conflicts to the current OEF, OAF, O & D conflicts.

This includes primary care, mental health integration, and an approach that considers the mental health need of veterans with a course that is designed to promote an optimal level of social and occupational function and participation in family and community life for our veterans.

We continue to promote early recognition of mental health problems. Veterans are routinely screened in primary care for PTSD, depression, substance abuse, traumatic brain injury, and military sexual trauma. Screening for this array of mental health problems helps support effective identification of veterans needing mental health services. And it promotes our suicide prevention efforts.

In September of 2013, the New Mexico VA healthcare system hosted a mental health summit with over 87 community participants. The New Mexico VA healthcare system will be hosting another mental health seminar in September of this year with a focus on mental health access. And there will also be a separate track on homelessness.

There are four vet centers in New Mexico including Albuquerque, Farmington, Santa Fe, and Las Cruces.

The New Mexico VA healthcare system is committed to providing high-quality, safe, and accessible care for our veterans. We will continue to focus on improving veterans' access to care and have instituted numerous changes that are showing positive results.

Our location presents unique challenges with regard to distance, culture, and constrained healthcare markets. Our rural health programs are robust. And we will continue to strive to meet the needs of veterans in rural areas.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today in my 30th day on this job. My colleagues and I will be pleased to respond to any questions you or other members of the committee have.

[THE PREPARED STATEMENT OF ELIZABETH FREEMAN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much for your testimony. Earlier this year PC3 was initiated. How has PC3 been utilized here in the Roswell area?

Ms. FREEMAN. Mr. Chairman, I'll ask Dr. Robbins to respond.

Dr. ROBBINS. I'm happy to.

Mr. Chairman, I believe it's actually been utilized—it's been utilized to some degree. But not as much as would be optimal. And one of the—although there is fee basis in this area to the tune of about \$300,000 or more, PC3 has been not utilized very well.

That's one of the reasons we actually had the CEO of TRICARE come to the facility and meet with us about issues and found that to be a very productive conversation.

And one reason that we are looking at mental health access in the Roswell area is that those individuals go to PC3. So we're beginning to lay the tracks and do more interaction with them.

The CHAIRMAN. Can you just explain for us a little bit why it hasn't been utilized as much. It's my understanding that there are ten mental health providers here in the area. And that obviously is a key.

Obviously the older veterans seem to want to have a face-to-face. Many of the returning Iraq and Afghanistan veterans seem to be comfortable with video teleconference, they Skype a lot with their families so they're okay skyping with a physician. But why do you think you're not utilizing PC3 much here?

Dr. ROBBINS. Sir, I think the VA model has largely been—we provide what we can in-house and send out-of-house as a secondary plan. I think that's something that's one of the very things we need to reevaluate now. And we're in the process of redoing that.

The CHAIRMAN. I hope you do. I think what we found is that the VA, although they do provide quality healthcare and many veterans are satisfied with the healthcare that they're receiving, it has become very apparent to me that the VA wants to grow itself to the detriment in many cases of the veteran.

Even in your comments, Ms. Freeman, you talked about testimony, initiatives, where you're recruiting and adding mental health specialists, increasing telehealth, and reorganizing programs. But you didn't in your testimony talk about face-to-face visits in the local communities.

VA always seems to want to protect its own bureaucracy. Veterans need to be able to get the care they need where they want to get it and when they want to get it. And we are delivering healthcare today, the whole of healthcare.

But the model is the same model for civilians. Forcing people to drive to facilities? Why? Because you have to have the patient census in those facilities in order to justify the facility being here.

That's not necessarily in the patients' best interest. So why do you think it's—and I'm not going to pick on you really.

Why do you think it's so hard? Is it just because of the way we have been doing it for so long?

Ms. FREEMAN. So if you don't mind, Mr. Chairman, my comments are from my experience in Palo Alto. We have facilities from Palo

Alto to Sonora down to Monterey. And we do face that same struggle.

Sometimes it isn't the desire to keep it in-house because we do want to treat each unique veteran and give him or her the care he or she needs and has earned. Sometimes it's just a matter of, as one of the previous panelists had mentioned, just finding the right providers; that we know we want to ensure one standard of care in having the highest quality of care that we can provide to the veterans.

But I do think that the choice act is going to give us more latitude to partner with community providers to provide those services closer to home.

Dr. HIGHBERGER. I'd like to speak to that just from a mental health standpoint too.

There are two things that I think are very unique in the VA providing care. And I can say that my father was a Korean war combat veteran. He unfortunately was not eligible to get VA services because of income. And he had his own insurance and that's fine.

I do think it would have been really beneficial to have had the primary care services that VA has because it can pick up on these things that are very specific to people who have served overseas.

There are things medically that we look for, we hunt for these, to make sure they get addressed. I think that's something very unique about primary care. And that's why you see it close to home. I think it's the same way with mental health.

So I have worked in the community. I know what I see when people come in to me and they're diagnosed with bipolar disorder. No one has ever asked them if they've served.

So there's this sense of protectiveness I think that we've had. And it's not about the bureaucracy or the agency. It's just very frustrating for us, when we feel like we own that care and we're responsible for that care and we want the best care, that primary care and mental health are so tied to having served that we do tend to hold it more than sometimes I think we should.

And I think that this process going forward will push us to really help with the community, help them understand what they need to be looking for. Because there are other veterans who are not eligible for VA care who will benefit them from that knowledge.

The CHAIRMAN. And I think that's a great thing, because VA does a lot of outreach, trying to get veterans to come into the system and be able to use the system.

But I think you need to have outreach as well to the local providers. I think that's a great first step. And mental health I think is one of the those things that, VA has to be in charge of.

You can still do some of it on a non-VA care basis. But again why force a veteran to go to VA and get a flu shot. Why even knee or, hip replacements, those kind of things can be done outside VA to allow you to do the things that only you can do. So I appreciate that.

Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman.

Ms. Freeman, you heard Mr. Moncrief earlier talk about telehealth in regards to mental health counseling. And he felt it was impersonal.

Is that a drawback that can be overcome or is it unique to each individual or how do you respond to that concern?

Ms. FREEMAN. So my experience has been that I think, as the chairman just mentioned, that with the newer veterans they're much more comfortable with the video telehealth. And they even say why would you do it any other way. But then you have other veterans of other eras.

And, you know, I think it's incumbent upon us to meet each veteran where he or she is and provide the kind of services that are going to be effective for them. If telehealth medicine is not going to be effective for veterans of other eras, then we have to find a way to provide that face-to-face care, we have to find the providers that we know, the protocols that we know how to treat those symptoms that are unique to servers of this country.

Mr. LAMBORN. Okay. Thank you. Now, you said in your testimony that you were doing an outreach by going to different communities. Could you elaborate on that, especially concerning Roswell in particular, where you've sent teams out to meet the folks.

Ms. FREEMAN. Sure. If you don't mind if I ask Dr. Highberger to talk about that.

Dr. HIGHBERGER. Yes. What I would say is that in general we're trying to partner a lot more with the community in many ways. So, for example, the issue of homelessness was brought up and how do we help, you know. You're a service officer here and you're trying to help, you know, your colleague and what is there.

And I think there are times where I think as VA we have to recognize we aren't the answer in every way, shape, or form, that we have to work with the community. There may be times where we need to help develop something up.

One way that I think we've demonstrated that we can do that is through the SSVF program, which is supporting veterans and their families through national grants.

If those grants can help a community agency who is interested and committed in working with veterans to develop that kind of service that the veteran service officers and the veterans and other stakeholders are all identifying as a definite need, then that's a good way of trying to partner in this and get those solutions together.

So we might not be able from VA to be in every city and every county and have our staff there. And I think we just have to accept that it's not all about us. It's really about the community as well. And they've got great services that can assist us.

We've got several instances of that throughout with incredible partnerships that really work as if they all work for the same agency. So I think that's really a demonstration of success is where you find it.

Dr. ROBBINS. I also think that one of the things that happens certainly in New Mexico and probably in other locations is it's very easy to sit at the home facility and think of that as the world. And I think part of what we have to do is make specific and conscious efforts to reach out individually and personally to locations around the state and set up events here.

I know that we have a plan to begin visiting the different parts of the state every month by a member of senior management. And we have a homeless stand down coming up in I think it's Carlsbad and one other location in the Southeast.

So part of it is a conscious effort to reach out, understand the problems, and be on the ground in places like Roswell, Artesia, and others.

Mr. LAMBORN. Ms. Freeman, what do you think the Patient Centered Community Care program, PC3 in shorthand, what do you think about that program?

Ms. FREEMAN. So I think any vehicle that we have where we can provide more timely access and high-quality care to the veterans is fantastic.

And I really appreciated it when Dr. Robbins told me that Mr. McIntyre personally came to the Albuquerque VA last Friday. And when Mr. Gibson was Acting Secretary, he had asked us if we had any challenges with PC3.

And he mentioned how closely Mr. McIntyre and TriWest is working with VA. And I think that personal meeting demonstrates the kind of commitment that TriWest has to meet the VA's needs and providing care closer where veterans live.

Mr. LAMBORN. Okay. Thank you.

The CHAIRMAN. Mr. Pearce.

Mr. PEARCE. Thank you, Mr. Chairman. Ms. Freeman, you've heard the comments about the payment and it's something that I hear frequently by providers. Is that something that you all dedicate an office to or staff to or how do you handle those complaints?

Ms. FREEMAN. Sure. So there is a centralized process for fee payments; is that correct?

Dr. ROBBINS. For the New Mexico VA health, there is a coherent centralized office under one management.

Mr. PEARCE. So it exists already?

Dr. ROBBINS. Yes.

Dr. HIGHBERGER. Well, there are two separate things. And I think what you may be asking about is the actual payment of the bill. So the payment of the bill is actually a partnership that VISN 18 has developed with VISN 19.

We were struggling with paying our vendors. We knew that was not good for our relationship and that ultimately hurts our veterans. So what we did was we found a VISN who was doing it well. And instead of trying to rebuild or duplicate, we said can we partner.

And we helped with resources to them to then pay our bills. So in the facilities we have a non-VA care office who coordinates, who makes sure that everything is functioning correctly, who makes sure that the billing to VISN 19 is going to pay our bills.

Ms. FREEMAN. If I may add. A target level similar to what occurred a few years ago in the third—in the medical care costs recovery, whatever the acronym for that is, for veterans paying in when they have a co-pay. That was centralized regionally with a similar effort that should be going forward in FY 15 to further centralize those payments.

Mr. PEARCE. I'm just trying to draw attention with a little WD40, because it doesn't work very well a lot of times.

Ms. Freeman, does the honor guard come under VA? Honor guards for burials, is that a part of the VA?

Ms. FREEMAN. I would be happy to follow up on that.

Mr. PEARCE. Let me make a comment in case it does. I've got a young soldier here that came today. He just got notified by text message that they were going to cut that department out or they were going to cut funding to it.

First of all, that's not the way that you should be telling people that have been cut back. And then secondly, you wonder why. Because the VA budget is not being cut. So it may not come under you. I've been asking questions about that. And I still don't have an answer for myself.

Mr. Robbins, thank you very much for making sure this pilot project is ongoing, because it is buzzing around the state. People have heard about it, there's a sense of excitement, there's a sense of relief. And I appreciate that you have honored your promise there at that meeting.

How many people are going to actually be seen in this pilot project? Our agreement was one day. They've actually made it several more days to make it more comprehensive. How many people are we going to see, just give us an idea of that?

Dr. ROBBINS. It's roughly nine, it should be nine patients today and tomorrow that are primary care.

Mr. PEARCE. At one point you had 35 or 36. Did they just not materialize, what happened there?

Dr. ROBBINS. It was a variety of issues. The primary issue was the primary care was wanting to focus on a small enough group to where we could be sure that we got something going as an additional start.

Mr. PEARCE. Do you have an attempt to kind of continue this on and then maybe expand it out? Because the further you get away from Albuquerque, the longer the drive and the more intensity.

So I was in Hobbs, Jal, and back around. They were saying when are we going to get our pilot project. So what's your intent on the longer term?

Dr. ROBBINS. Yes, sir. I just want to comment that I want to thank you very much for raising this issue to us and for collaborating with us. It's been an excellent experience, very positive for the veterans. And we are thoroughly committed to this and intend to continue it.

Mr. PEARCE. Mr. Chairman, I have more questions I would like to save for the second round.

The CHAIRMAN. Ms. Freeman, in May of last year, the Undersecretary for Health instructed you to hold the health summit. And you did hold a mental health summit. And you've said you've got another one coming up I guess in September or October.

One of the things they asked you to do was identify community partners. Who did you identify as your most active community partners during that summit? And did you enter into any formal agreements with any of them?

Dr. ROBBINS. Sir, we did not. The New Mexico VA did not enter into any formal agreements based on that summit. There was a lot of dialogue. There were two very important issues discussed and I believe improved on.

One was access by who to call, who to call if you have a problem. We're in the VA, we're in the VA system to call. And the second was the suicide prevention coordinator developed some additional contacts and ability to do more outreach.

The CHAIRMAN. How do you schedule your appointments now, how is that working? And mostly primary, maybe mental health. This is the whole thing that blew up.

Dr. HIGHBERGER. Right. I can speak to that. What we're doing and we have been doing for several years in VISN 18 is trying to audit, trying to find those areas to recommend specifically to a facility to modify, and trying to get to where we're in compliance with the scheduling directive; and most importantly that we're able to thus get people the appointments when they need them, where they want them.

And it has been a challenge. It's taking a long time. The efforts that we've been doing we've ramped up the speed of. I think it's been hard for our schedulers to fully understand and implement. I think it's a complicated process. It's taking a lot of reteaching to get it right. But we're making sure we get it right.

The CHAIRMAN. What's the complicated process?

Dr. HIGHBERGER. So in that system, again it's a blue screen DOS system, it is a challenge for the staff.

The CHAIRMAN. I'm sorry. But is that not part of the problem, you've got a DOS system today?

Dr. HIGHBERGER. I agree. I absolutely agree.

The CHAIRMAN. Do you know how many hundreds of millions of dollars have been appropriated to VA for IT and we're still using a DOS scheduling system?

Dr. HIGHBERGER. I agree.

The CHAIRMAN. Not your fault.

Dr. HIGHBERGER. I agree. And when people come in, some people—I'm old enough, I remember the DOS system and blue screens and how you have to type commands prior to better technology. Some people have never even seen that technology and they're hired into those roles. So that's one issue.

The second issue that I think is more important is lot of people who were doing it wrong had no clue they were doing it wrong, including even now with retraining we have some people speak up, they say this is what you do, they are able to verbalize it.

And one of the benefits of—our staff went down observing them scheduling—is that they will then not do it correctly even after they just verbalized it correctly.

So there's more education and more communication that has to occur. There's a lot of auditing that has to occur. We want to get it right. We're trying every which way to get it right. But it's still a work in progress.

The CHAIRMAN. Whose responsibility is it to make sure it is done correctly?

Dr. HIGHBERGER. I think it comes at many levels. I think one is that we have a direction that we're given that is challenging, it's not what we do in the community. So we talk about desire dates.

These are things that don't get looked at or examined in the community. So it's a new concept to try to teach people. These are

entry level positions typically in the system. So these are people's first exposure to VA. And there's a lot of learning.

They're also high turnover positions. So even if you are doing the right thing and supervising, you're following through and you're educating, your staff are turning over repeatedly.

And it's a good thing because they're usually getting promoted. Most of these people are veterans, most of them are getting promoted up through the system. But you've got to start over then.

So I think it comes from the supervisor, it comes from the employee, it comes from what we're directing above, you know, about what to do. And it's not been a simple thing to fix.

The CHAIRMAN. Doctor, one of the things that I've heard from physicians in particular is that they have no control over the scheduling system themselves.

And so if you say this patient should be seen within five days, you don't know whether that patient gets seen within five days. And we now have horror stories out there that have occurred because the doctor's orders were not followed. How do you prevent errors like that from occurring?

Dr. ROBBINS. So I agree, sir, that that is probably one of the worst things that can happen. And one thing that we've done is in our facility, one of the barriers to getting the scheduling process right has been that the schedulers were scattered all across the facility or organization.

We're beginning to unify that and pull in schedulers into a single organizational unit so that we can train them consistently, so that they can feel that they're getting a consistent message about that.

I will say that, because of my concern about that specific area, when I went around to each of the CBOCs and as well as in the main facility, that is something I specifically asked about for everyone.

If the physician orders something, the physician orders some follow-up, and you cannot meet that, meet what the physician wants, you must go back to the physician or the provider and get clarification. It has to be a medical decision.

The CHAIRMAN. As the acting interim medical center director, do you still see patients?

Dr. ROBBINS. I do not, sir.

The CHAIRMAN. Are you credentialed?

Dr. ROBBINS. Sir, I have credentials as a part of my normal job as CMO. But I don't have privileges so I'm not able to practice.

The CHAIRMAN. We keep talking about lack of physicians, yet we have physicians all through the VA system that don't see patients. I mean I know there's a lot of things you can't do.

But in an emergency, when we need to serve the people I find that hard to believe. But that's the way VA has always done it. So again I'm not trying to come down on you. But I'm just telling you, do you have any idea on how many physicians work for VA that don't see patients?

Dr. ROBBINS. I don't, sir.

Dr. HIGHBERGER. I would like to respond to that. It's my impression, this is just my impression, that it's about 50/50 with people continuing to see patients when they take on a full administrative load.

I do still see patients, I am credentialed and privileged. I have tried to keep even just a half day every other week. And I can tell you that the administrative duties have wiped that out nearly completely.

Our business was downsized, I don't have support staff. It's not as simple as just dropping my duties. If I'm not there as the acting chief medical officer to review those applicants for the Phoenix facility, for Albuquerque, for El Paso who have issues with their credentialing, that person can't get hired until I do it. I'm the only one that can do it.

So there's a real trade-off there. Now, I do still want to see patients. I was assisting El Paso by telehealth. I can tell you that that pull for me to do that is very strong. But when I go over to Phoenix or I go to a CBOC that I'm privileged to see patients in, there isn't the space for me.

The CHAIRMAN. Part of the bill is we have billions of dollars for space. But, you know, one thing the VA is not good at doing is thinking outside the box. Instead of extending the hours of a facility, they want to build a whole new facility.

It's like why not extend appointment times that just happen to be when a veteran probably could come so they don't have to take off work to go to VA.

But because VA wants to do fairly normal working hours, we've got to build a whole other facility because we don't have the space. So we're going to have to crack this nut. And it ain't going to be easy.

Dr. HIGHBERGER. I agree. And I did work extra evenings even to support that CBOC to do that.

The CHAIRMAN. You said the key. You said the key. Support is important. I mean I don't know how many veterans have told me their doc never looks them in the eye because they're staring at a stupid computer screen.

Why? Because they have to fill out all kinds of garbage to CYA VA 20 years down the road if we ask did you do this, did you do that.

Look, that's not what a highly skilled, highly paid physician should be doing. They don't do that in the private sector. But VA does it. We've got to fix that.

Dr. HIGHBERGER. I agree. I think one of the most important things that I see in that bill, at least specifically speaking to VISN 18, is space. So I've had times where I've scheduled patients.

And I literally had to take a patient over into my VISN office that is not set up for seeing patients. People open up my door and interrupt. And I had to stop because it wasn't right, it wasn't right.

And so, you know, I think with additional space, you're going to see a lot more patient care occurring from administrative physicians. It is a desire of mine to definitely do that.

The CHAIRMAN. I'll bet you don't. I'll bet you don't. Because that's not what they're accustomed to doing. But I hope you're right.

Mr. Lamborn.

Mr. LAMBORN. Thank you. Let me build on this really important line of thought that the chairman has been pursuing.

I know VA has a lot of metrics. So many that that consumes a good part of your working day. Do you think that we could really

reduce the number of—I know probably every single one of those is well-intentioned. But can we do a drastic job of reducing that so that more patients can be seen during a given day, any one of you?

Ms. FREEMAN. So I really appreciate the question, because there used to be something called a performance measure work group nationally. And I was one of the few field members as a facility director on that group.

Every time a new measure got added, you know, if it wasn't myself personally or my physicians, my nurses or my staff would be impacted by those additional metrics.

And so I completely agree with you that my observation in the community where I live and my regular job, they have a corporate scorecard that has ten or less. And even the board pushes back and says it should be seven or less corporate goals.

And that's what community healthcare systems, at least what I've seen, operate under. So we have a very clear goal deployment.

I'm not saying there are lots and lots of things we have to do in the background because we are healthcare and there's lots of outside entities that audit us. And it's very important to ensure the quality of our care.

But we need to be able to articulate that to everyone, from the front-line employee to the head administrators, so that everybody is working toward the same direction.

Mr. LAMBORN. I really—I hope that this is one of the things that the Congressional CARES Commission—I hope I pronounced that correctly. But one of the commissions that the bill sets up, Mr. Chairman, that's going to look at VA from the ground up.

I really know we need to get into this so that highly trained care providers can get back to the basics of what they are trained to do and do not have to have their face glued to the computer screen like the chairman just said.

Dr. Highberger, what do you say about that?

Dr. HIGHBERGER. I think what I see is that you throw so many metrics at people—it becomes a blur. I think sometimes it's easy to get lost in the real message that's supposed to be there. I know for VISN 18, what we've been preaching for years is that it is not about the metric. The metric reflects the care.

I don't know how well we get that message communicated all the way down to every employee. But I know that's what we believe. I think, if you look at it that way, having more metrics perhaps is okay. It's just different reflections of the care.

I think that the way we've done it, though, we've had too many splittings off in too many directions and then losing the real focus, which is the veteran and what is the care like for them, how are they experiencing it. It doesn't matter what the metric says.

Mr. LAMBORN. And lastly, and maybe this is a metric. But what is the average waiting time in New Mexico for primary, specialty, and mental healthcare?

Dr. ROBBINS. Sorry. Give me just a minute. The average primary care wait is 47 days. The average specialty care wait is 64 days. And the average mental health wait is 41 days. Those are new patient wait times.

Mr. LAMBORN. New patient. If someone calls in for ongoing care, it could be different, higher, lower? Do you have those numbers?

Ms. FREEMAN. The VA is reporting wait times in two different ways. He just gave you the prospective wait times. And the completed new patient primary care average wait time is the end of June; is that correct?

Dr. HIGHBERGER. Correct. It's appointments that were completed at the end of June.

Ms. FREEMAN. So for appointments it's the end of June. For primary care for new patients the time they actually wait—

The CHAIRMAN. Wait, wait, wait. What the hell is a—what did you just call it, a primary prospective new patient? What kind of—you guys, quit. You keep changing the rules.

The CHAIRMAN. All we want to know is how long does it take a veteran to see a doc, period?

Dr. HIGHBERGER. Sir, I agree.

The CHAIRMAN. Don't give me three different ways to do it. This has gone real well up until this last little bit.

Dr. HIGHBERGER. So these are the data that are published on the website for transparency purposes.

The CHAIRMAN. That doesn't mean anything. I don't care where it's published.

Dr. HIGHBERGER. I understand. This is what we're—

The CHAIRMAN. Anybody in here get a primary care appointment within 40 days?

There ain't a hand up. None. When did we start this new measuring?

Dr. HIGHBERGER. The data is the same.

The CHAIRMAN. No, no, no, no. When did we start this new process? Because it's something that I've never heard of before.

Dr. HIGHBERGER. So this is the new process.

The CHAIRMAN. No. My question is when did you start it?

Dr. HIGHBERGER. It was in May.

The CHAIRMAN. That's all I need to know. When the crap hit the fan, you changed the metric again. Stop. Stop it. These veterans deserve better.

Dr. HIGHBERGER. I agree. We have no control over these metrics, sir.

The CHAIRMAN. Yes, you do. Raise your voice. Tell your leaders it's not working, your veterans aren't being served. Don't tell me you can't do it.

Dr. HIGHBERGER. We are and we have.

Ms. FREEMAN. And we will.

Dr. HIGHBERGER. And we will continue.

The CHAIRMAN. Good. Steve.

Mr. PEARCE. Thank you, Mr. Chairman. One of the things that I hear literally from providers from VA and from veterans alike is fear of reprisal.

So many people did not want their names used as I talked about their items. Are you all addressing the fact that we can't cure the problems when people can't talk about it inside the system?

Ms. FREEMAN. Absolutely. And one of the things at my home facility that we promulgate and that I have shared with some of the executives in VISN 18 to see if they're interested in trying to hear is we really want a healthcare system where every employee that comes to work every day sees themselves as a problem solver.

So they're all contributing to continuous improvement and improving the quality of care we provide to veterans. And it's been stated, you know, over 30 percent of our employees are veterans. We are veterans serving veterans.

Mr. PEARCE. But there's still fear of reprisal.

Ms. FREEMAN: Absolutely. And as the chairman mentioned at the very opening of this hearing, a culture is our habit, it's the way we do things. And it won't change overnight.

But we have to start. We have to engage every employee every day and continuously improve. And raising their hand saying the issues that they think need to be addressed and have a system of closing that loop and addressing those.

Mr. PEARCE. Dr. Robbins, we have discussed in one of the previous meetings a practice where you have the physician leave. You assign his patients over to a doctor that didn't see patients in order to make the system sort of look like it's working on paper or the computer. Has that situation been resolved?

Dr. ROBBINS. Yes, sir.

Mr. PEARCE. That's all I want to know. Just it's been solved. What is the scope, Dr. Robbins, of the nine people being seen here today and in the future, do we have any PTSD, anybody seeing mental health providers here as part of that?

Dr. ROBBINS. So the nine folks today and tomorrow, those are all primary care. Those are primary care appointments.

Mr. PEARCE. So you are open to people seeing mental health professionals here?

Dr. ROBBINS. Absolutely.

Mr. PEARCE. So you were there for a fairly energetic exchange between your staff member and myself over the fact that people—doctors, hospitals, will not see people for basically the cost of gasoline.

I suspect that's the reason that we've never moved any further towards letting veterans see local providers, because of that internal belief that the system doesn't need to change and will never need to change.

Is there any more clarity inside your staff there in Albuquerque about the willingness of local doctors, local hospitals to see patients and the reasonableness of the service?

I mean you heard one guy say—you heard Mr. Moncrief say his appointment was 75 bucks. And you've got to pay him \$160 for gasoline. Is that sinking in, especially the gentleman that we had the discussion with?

Dr. ROBBINS. Yes, sir. We clarified that shortly after you left.

Mr. PEARCE. Okay. I think my last—that was my last question. No, no. I have one more. What level did you have to go to to get this pilot project approved, were you able to do it or did you have to go to a higher chain of command, did you have to go to the Secretary level?

Dr. ROBBINS. Sir, we spent some effort and some time trying to figure that out. But as it turned out, these were actions that were within our existing authority at the facility level.

Mr. PEARCE. So you all were able to make the decision in Albuquerque, you did not have to get an approval to run this project here?

Dr. ROBBINS. That's correct, sir.

Mr. PEARCE. Mr. Chairman, I yield back. And thank you very much for having this committee hearing here in Roswell, New Mexico.

The CHAIRMAN. I want to thank everybody for attending. And I do want to say thank you, VA, because you are the tip of the spear. And don't think that, because you're way out in Albuquerque and the central office is way over in Washington, that you can't make a difference, because you can. You can.

Your veterans are telling you what they need. The system has got to change. As a mental health provider, you know you have to listen. And unfortunately that's not been the case at VA for a long time.

We have a golden opportunity to help VA become the very agency that they should be. And I have said it a dozen times in the last week.

Thank you for being here. We truly appreciate what you do on a daily, weekly, and nightly basis because I know you work hours that many don't think you do.

I would ask unanimous consent that all members have five legislative days in which to revise and extend their remarks.

The CHAIRMAN. Again, thank you, everybody, for being here. This hearing is adjourned.

[Whereupon, at 1:00 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE CHAIRMAN JEFF MILLER

Good morning and thank you for joining us today.

I am Jeff Miller—Chairman of the Committee on Veterans' Affairs for the United States House of Representatives and Congressman from the First District of Florida, where—as we like to say—thousands live like millions wish they could.

I am joined here today by senior Committee Member and the Congressman from the Fifth District of Colorado, Doug Lamborn, and by our friend and colleague and your Congressman, Steve Pearce.

I know I speak for Rep. Lamborn (Doug) as well when I say that I am grateful to Rep. Pearce (Steve) for his hard work, leadership, and advocacy efforts on behalf of New Mexico's servicemembers and veterans.

I am grateful to him for inviting us to New Mexico today and am honored to be here in Roswell with all of you.

Before I go any further, I would ask all of the veterans in our audience today to please stand, if you are able, or raise your hand and be recognized?

Thank you so much for your service.

Ensuring that you and your veteran friends, neighbors, and colleagues in New Mexico and across the country have timely access to high-quality healthcare through the Department of Veterans Affairs (VA) is why we are here today and I am grateful to you for joining us this morning.

As you all know, in April, a Committee investigation and whistleblower revelations exposed widespread corruption and systemic access delays and accountability failures across the VA healthcare system that left thousands of veterans—including some right here in New Mexico—waiting for weeks, months, and even years for the healthcare they earned through honorable service to our nation.

In the four months since, the Committee has held multiple hearings to get to the bottom of the Department's deficiencies; VA senior leaders have resigned and been replaced; and, nationwide initiatives have been undertaken.

Just last week, Congress passed a bipartisan Conference agreement that will improve accountability for VA employees; increase access to care for veteran patients facing lengthy waiting times or residing far from the nearest VA facility; and pave

the way for long-term reforms that will dramatically improve the Department for veterans today and for generations to come.

Needless to say, it has been a busy summer.

However, our work is just beginning.

During today's hearing, we will discuss the challenges Roswell veterans experience accessing care—particularly mental healthcare—through Veterans Integrated Service Network (VISN) eighteen and the New Mexico VA healthcare System.

In short, things could certainly be better.

VA's nationwide access audit found troubling scheduling practices were in place at the Albuquerque VA Medical Center and I want to hear from our witnesses—local veterans and local VA officials—how those practices have impacted the care veterans receive here and what actions have been taken and still need to be taken to improve access to care for New Mexico veterans.

I look forward to our discussion this morning and to taking your thoughts and ideas back to Washington when we leave.

I thank you all once again for being here this morning.

PREPARED STATEMENT OF JOHN TAYLOR, SERGEANT, U.S. ARMY (100% COMBAT
DISABLED RET.)

Chairman Miller and Members of the House Committee on Veterans Affairs, it is an honor to provide testimony before you today.

My active duty combat military experience was with the 101st Airborne Rangers in Vietnam. After seeing many of my brothers die in heated combat situations within the infamous A Shau Valley area of Thua Thien/Hue, and being shot twice and bayoneted on the same day, dying on the MASH unit surgery table (and obviously returned to life), I never imagined any of us would come back home to die directly related to post combat medical care in our VA hospitals. Sadly, as you are now aware, that has become a painful reality.

After being combat disabled retired from the military, I completed my degree in Business Administration, with a Pre-Med Biology minor. Half of my career was spent in corporate management for Dun & Bradstreet. More important to this hearing, I spent the last half of my career (12 years) in medical administration; hospital director, nursing home administrator, medical hospital-satellite manager, urgent care center director, substance abuse center director and psychiatric center director.

In the interest of saving this Committee time with respect to my evaluations and solution recommendations, please let me refer you to a previous field hearing you had on 10 July 2014, "Service should not lead to suicide: Access to VA's mental healthcare." One of my younger brothers-at-arms, U.S. Army (RET.) Sgt. Josh Renschler's gave an excellent testimony before this Committee. Even though we came from different wars, basic problems, observations, and suggested resolutions are essentially the same. I can, however, give you a significant variation I would term "acute rural'ality". Being in a rural, desert community, systemic problems encountered throughout the country are greatly intensified in southeastern New Mexico. As a quick example; Following the Cares Commission findings during President Bush's last term in office, a Director of Rural Administration was created to help eliminate our acute problem of rural access in our area. As it turned out, that rural administrator responsible for resolving our problems was none other than our Administrator of the Albuquerque VA Hospital,—the very person, historically, refusing our request for local fee-base services. Ineffectual outcomes are obvious.

For the last nine years, I have published a weekly "Veterans Advocate" column in our local newspaper, the Roswell Daily Record. The column is a volunteered, non-compensated, freelance work, having no allegiance to any person or group, except to my brother and sister veterans. Over the years, I've made members of both sides of the aisle uncomfortable to say the least. However, the majority of my rants have now shown to be true. Like so many other public-forum veterans' advocates are asking, "Why did it take the recent deaths of so many of us to prove what we advocates have been claiming for so many years was true?"

It is important to note, our deaths were majorly not due to medical care provided by our VA medical professionals (physicians, nurses and medical support personnel), but from administrative "games" played by VA administrative leaders and by system oversight groups. I've made that statement publicly, several times over the last nine years, only to be ignored or politely told either "were working on a resolution" or "you're not correct in your accusations". Finally, saddest of all, my claims have been validated with the many deaths recently "uncovered" (and still being uncovered) thanks to courageous whistleblowers. The retaliation they received, as you all

have been made aware, is the perfect example of the VA's response to anyone questioning the VA's activities. Veterans, families and friends have not, and continue to not, come forward due fear of reprisal. The VA has historically denied this to be true, but as you yourself have recently seen, the VA seems to have a problem with the truth. I personally can offer proof this has occurred long before the recent "awakening".

I have respectfully submitted a few of my VET ADVO columns in support of my testimony today, most of which are 6 to 9 years old. This illustrates real-life catastrophes I have encountered over my nine years as advocate, which were literally ignored or denied as being accurate by our State VA administrators and Government officials. We all now know how invalid the VA denials were, and still are. Two specific sets of columns illustrate factually the problems and battles we have faced with the Albuquerque VA Hospital administrators, consistently denied by the VA as being accurate.

1. The first was a series of columns I did on a chronic PTSD veteran who over the space of more than one year threatened to commit suicide due to his Desert Storm nightmares. His wife approached Col. Ron McKay (USMC Retired) and me with horror stories of her lack of effective treatment for her husband by the VA. Apache (my column name for my brother to respect his privacy) had undergone several "treatment modalities" lasting from three days to three months in-patient sessions. More than once, he was sent home in a cab (for a two and one half hour drive), before which he would ask the driver to "swing by" the nearest Albuquerque liquor store to make his journey easier. His primary substance abuse/dependency directly related to his PTSD was alcohol. Knowing this, his treatment team and or patient discharge planner should have known this was a perfect storm doomed to failure. Each time, Apache return home totally inebriated, once again threatening suicide. He was instructed by his Albuquerque VA treatment clinician to report to a local VA social worker for "after-care". During the first visit (Apache and his wife), as reported by his wife, the counselor asked, "So what is it you want me to do? You know, you could go to AA and get some help." A furious Apache and his wife got up and left. In my experience as a director of a psychiatric center and an inpatient substance abuse center, after-care for either malady requires, at a minimum, the services of a certified psychiatric counselor or certified substance abuse counselor (for facility licensure by Texas and New Mexico), not a social worker. Eventually, Apache was found dead one night outside his house, in spite of repeated request to the VA for help keeping him alive. The VA response? He was non-compliant. In other words, they gave up!

2. The second set of columns dealt with several cases I followed involving the unacceptable six-plus hour round-trip drive to the Albuquerque VA Hospital from Roswell. One involved an 86-year-old veteran with stomach cancer (with an active drainage catheter) who had to be driven to Albuquerque 2 to 3 times a month by his 87-year-old wife, who was in failing health herself. His primary care physician at the VA Artesia clinic had requested approval for him to be seen locally, in Roswell. That approval never came. To this day, I have the uneasy feeling Mr. Borum died prematurely due to the stress this put on his system.

3. Additionally, in one column I actually reported a conference call I had with VA Albuquerque Administrative Staff concerning fee-based (local contract) dental care for 100% service-connected veterans in Roswell. The assurances and "promises" of local contract dental care by administrative heads in Albuquerque were later found to be lies, subsequent to my telephone visit with a staff dentist at the Albuquerque hospital. When I approached the VA Hospital Administrator at that time, he refused to review the incontrovertible evidence I offered him. His response to me (several times) was, "My people don't lie!" I have reliable witnesses to that encounter. To the point of ineligibility for local care (fee-based services) in Roswell, Roswell has been denied local access to fee-based services because it was "determined" by the VA to be less than 40 miles from the nearest CBOC. That also has been a lie each and every time it was offered by the VA. Last week, I measured the actual distance from our nearest CBOC (Artesia, New Mexico), and found it to be (exactly) 45.6 miles to my front door, and 43.8 miles from the center of town, accurately showing half of Roswell is at least 44 miles from the Artesia VA CBOC (greater than the "less than 40 mile" rule). This certainly was not the 38 mile VA calculated distance given in our several denials for local contract services. Additionally, when Taos, New Mexico received a "shadow clinic" which we were also promised, we were denied due to the 38 mile determination. I did a study finding that Taos was in fact closer to its nearest CBOC than Roswell was to the Artesia VA clinic. In fact, there were over 100 clinics built in our quad-state region in violation of the "40-mile" rule.

I apologize for this lengthy testimony, but after nine years of reporting on these issues and warning everyone of the obvious, predictable outcomes, I hope this report

does not, once again, fall on deaf ears. Simply stated; (1) Systems monitored by its own department members (no matter the claims of independent watchdog status) do not and will not work. (2) Paying bonuses to upper echelon administration is a crafty mechanism created by "upper management" to milk the system. I know! I've been there. In my many years as a medical administrator, my reward (bonus if you please) was continued employment next year. The contrived reason for VA bonuses (reported in other House and Senate committee hearings) is to entice and retain competent administrators. That, Hon. Committee members, is a fallacy perpetrated on those who have not worked in the medical arena. Competence in our current VA administration (based on this bonus rule) has been proven grossly lacking among our current VA "hand-pick" wonder kids! In my experience, it's safe to say you would find a sufficient queue of qualified applicants for each VA administrator position you currently find "not up to par". Current doctors and medical administrators being RIF'ed (Reductions in Force) in the Administration's military drawdown could easily and effectively be placed in certain comparable positions recently found "lacking" within the VA administrator network.

I sincerely hope my testimony and attached resource materials will help you with your enormous task of keeping my brother and sister veterans alive once they return home, after surviving death on the battlefield.

I would be pleased and honored to answer any questions you may have. God bless you in your efforts, God bless my brother and sister veterans, and God bless our Nation. Thank you.

PREPARED STATEMENT OF RICHARD MONCRIEF

I would like to thank the committee for giving me the chance to speak out about the lack of Mental healthcare in the Southeast corner of the state.

I have been using the Mental Health services in the Artesia Clinic for several years now. With the loss of Dr. Peter K. Hochla we now are going to be forced to use the telemed system which is a very impersonal way of conducting mental health. The men and women who suffer from PTSD and TBI need to have a live physical being to talk to. Better yet to have Group Therapy with a skilled group leader and a Psychologist would even be better.

Having a warm body to talk to, in person is better than a Flat Screen for the patient. The talk is more personal and you can see the body movements and make better eye contact with the person doing the counseling.

When Dr. Peter K. Hochla was here every 3-6 months, I still needed to talk to someone to be able to let my hair down and be relaxed. I ended up hiring a MA, LPCC (Licensed Professional Clinical Counselor). I tried to use TRICARE, but they did not pay the going Medicare rate so I ended up paying for the Counselor out of my pocket.

There is a very great need for some kind of skilled counselor in this part of the Country.

PREPARED STATEMENT OF MS. ELIZABETH FREEMAN

Good morning, Chairman Miller, Congressman Pearce, and Congressman Lamborn. Thank you for the opportunity to discuss the New Mexico VA Healthcare System's (NMVAHCS) commitment and accomplishments in providing Veterans accessible, high quality, patient-centered care and to specifically address rural healthcare and access to mental healthcare in New Mexico. I am accompanied today by James Robbins, MD, Interim Medical Center Director for NMVAHCS, and Lori Highberger, MD, Deputy Chief Medical Officer and Mental Health Lead for the VA Southwest Healthcare Network.

New Mexico VA healthcare System Overview

The NMVAHCS serves Veterans in New Mexico, southern Colorado (Durango area), and west Texas. NMVAHCS is comprised of the Raymond G. Murphy VA Medical Center (VAMC) with 13 Community-Based Outpatient Clinics (CBOC). The Raymond G. Murphy VAMC is a Joint Commission-accredited, VHA complexity level 1a, tertiary care referral center located in the heart of Albuquerque, New Mexico. It provides a full range of patient care services with state-of-the-art technology as well as education and research. It is the only VAMC in New Mexico.

The Raymond G. Murphy VAMC is a teaching hospital, affiliated with the University of New Mexico School of Medicine and College of Nursing. It has an active part-

nership with Kirtland Air Force Base 377th Medical Group and collaborates with Indian Health Service and Tribal healthcare organizations. The facility has an active Community Living Center, a 26-bed Spinal Cord Injury Center, and a strong commitment to psychosocial rehabilitation and vocational rehabilitation. VA-staffed CBOCs are located in Artesia, Farmington, Gallup, Silver City, Raton, Santa Fe, and Northwest Metro (Rio Rancho), New Mexico. Contract CBOCs are located in Alamogordo, Truth or Consequences, Espanola, Las Vegas, and Taos, New Mexico, and Durango, Colorado. The VAMC is a tertiary referral facility for Veterans from the VA facilities in Big Spring, El Paso, and Amarillo, Texas.

Rural Health in New Mexico

The VHA Office of Rural Health (ORH) supports programs and initiatives in the areas of Veteran transportation, telehealth, resident and allied health student rural clinical training and education, and care closer to home via primary care and mental healthcare extension teams that leave the VA facility and treat Veterans in their remote communities. Over 45 percent (77,493) of New Mexico's 170,799 Veterans live in rural areas of the state. Approximately 74,713 New Mexico Veterans are enrolled in VHA healthcare, and 47 percent (34,982) of those enrolled Veterans live in rural areas. NMVAHCS serves a geographic area that is 121,826 square miles. ORH currently supports nine projects for a total of nearly \$1.9 million in the state of New Mexico. These projects increase rural Veteran access to mental healthcare, women's healthcare, primary care, pharmacy services, and neurology services. Five of these nine projects use telehealth to deliver healthcare closer to Veterans' homes.

One currently-funded ORH initiative is Home Based Primary Care (HBPC) for Veterans residing in rural areas near Santa Fe and Artesia. The HBPC program provides primary care services for frail, chronically-ill Veterans in their own homes. HBPC is available in the Gallup CBOC and is being expanded to the Santa Fe and Artesia CBOCs. Another ORH-supported initiative focuses on diabetes education and overall health and wellness for Southern Ute American Indian Veterans. NMVAHCS continues to work with ORH to develop innovative project ideas to increase rural Veteran access to care and services.

In the recent past, Farmington, Silver City, Raton, and Artesia CBOCs were relocated to new clinics with increased space. New clinics for Gallup and Santa Fe CBOC relocations will be activating in calendar year 2014. The Truth or Consequences Contract CBOC will have a new contractor in approximately one year.

Telehealth in New Mexico

The VA healthcare system offers expanded access to mental health services with longer clinic hours, telemental health capability to deliver services, and standards that mandate rapid access to mental health services. Telemental health allows VA to leverage technology to provide Veterans quicker and more efficient access to mental healthcare by reducing the distance they have to travel, increasing the flexibility of the system they use, and improving their overall quality of life. This technology improves access to general and specialty services in geographically remote areas where it can be difficult to recruit mental health professionals. In areas where CBOCs do not have a mental healthcare provider available, VA uses secure video conferencing technology to connect the Veteran to a provider within VA's nationwide system of care. The program is also expanding directly into the home of the Veteran using Internet Protocol (IP) video on Veterans' personal computers.

There is increased support for group specialty care through the expanded use of Clinical Video Telehealth (CVT) technology. The use of this technology in homes is on the rise, especially aiming to assist American Indian Veterans, who are the most rural, isolated, and transportation challenged. Other initiatives include expansion of telehealth specialty service, which includes anticoagulation monitoring; dedicated space for telehealth education for staff and Veterans of rural health service; and health fairs at NMVAHCS CBOCs.

In Fiscal Year (FY) 2013, NMVAHCS served 5,168 Veterans through telehealth, and 59 percent (3,031) of these Veterans lived in rural areas. Of these, 1,002 Veterans accessed mental health services through CVT in FY 2013, 90 percent (897) of whom lived in rural areas.

Mental Health Services Engagement Initiatives

VA is working closely with its Federal partners to implement President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The Executive Order affirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions.

On February 1, 2013, VA released a report on Veteran suicides, a result of the most comprehensive review of Veteran suicide rates ever undertaken by the VA. With assistance from state partners providing real-time data, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations, such as Veterans living in rural areas, who may need targeted interventions. This new information will assist VA to identify where at risk Veterans may be located and improve the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. The data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations as well as care settings, such as primary care, in order to replicate effective programs in other areas.

In an effort to increase access to mental healthcare and reduce the stigma of seeking such care, VA has integrated mental health into primary care settings. The ongoing development of Patient Aligned Care Teams to deliver primary care will facilitate the delivery of integrated primary care and mental health services. It is VA policy to screen patients seen in primary care in VA medical settings for PTSD, MST, depression, and problem drinking. The screening takes place during a patient's first appointment, and screenings for depression and problem drinking are repeated annually for as long as the Veteran uses VA services. Furthermore, PTSD screening is repeated annually for the first five years after the most recent separation from service and every five years thereafter. Systematic screening of Veterans for conditions such as depression, PTSD, problem drinking, and MST has helped VA identify more Veterans at risk for these conditions and provided opportunities to refer them to specially trained experts.

VA operates the National Center for PTSD which guides a national PTSD Mentoring program, working with every specialty PTSD program across the VA system to improve care. The Center has also begun to operate a PTSD Consultation Program open to any VA practitioner (including primary care practitioners and Homeless Program coordinators from every location) who requests expert consultation regarding a Veteran in treatment with PTSD. So far, 500 VA practitioners have utilized this service. The Center further supports clinicians by sending subscribers updates on the latest clinically relevant trauma and PTSD research, including the Clinician's Trauma Update Online, PTSD Research Quarterly, and the PTSD Monthly Update.

To support Veterans who use VHA mental health services and build on the work of the 2012 Executive Order from the President, VHA has hired and deployed over 950 peer support staff to mental health programs across the country. Peer Specialists are Veterans who have been successfully and actively engaged in their own mental health recovery for a minimum of one year and who are trained and certified to provide peer support services. Peer Specialists work as members of mental health treatment teams and help Veterans achieve their treatment and personal goals, and they demonstrate that recovery is achievable.

No Veteran should have to wait for the care and services that they have earned and deserve. NMVAHCS intends to continue to work to meet Veterans' needs using the following initiatives:

- Recruit and fill mental health vacancies.
- Explore recruitment incentives to entice psychiatrists to relocate to NMVAHCS. There is an industry shortage of psychiatrists.
- Increase the number of Albuquerque-based mental health clinicians trained in and certified to deliver telehealth and other virtual care modalities such as CVT in the home to provide increased access for rural patients.
- Realign all outpatient mental health programs under one outpatient Mental Health Division to increase patient access to specialized mental health services.

Conclusion

NMVAHCS is committed to providing high-quality, safe, and accessible care for our Veterans. We will continue to focus on improving Veterans' access to care. Our location presents unique challenges with regard to distance, culture, and constrained healthcare markets. Our rural health programs are robust, and we will continue to strive to serve Veterans in rural areas.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I would be pleased to respond to questions you or the other Members of Congress may have.

